Frequently Asked Questions About Systems of Care, Medicare and Medi-Cal

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What is a System of Care?
A mental health system of care is both a conceptual model and a service delivery system for providing mental health services to a target population, usually individuals with the most severe mental disabilities. The essential components are a single point of responsibility for the client, coordination with other involved human service agencies, and decision making based on an evaluation of outcomes. Other components of systems of care, which are also critical to any responsive mental health system, include meaningful involvement of clients and their families (as appropriate) in treatment planning, client-centered services, cultural competence, age appropriate services, and an array of services focused on the person's mental health treatment and other supportive services needed to maintain residence in the community. Funding for systems of care can come from a variety of sources. Federal, state and private grants are often used to establish the infrastructure. Services are generally covered by the regular funding streams including realignment, state general funds for managed care, county general funds, grants, reimbursements from federal programs (Medicaid and Medicare), and other third party payors.

Are systems of care recognized nationally for children and adults?
The model for children's systems of care in California, originally developed by Ventura County, has been used as the national model for the Child and Adolescent Service System Project (CASSP) and for federal system of care grants. The federal Health Care Financing Administration (HCFA) in a recent letter to states affirmed HCFA's commitment to the Assertive Community Treatment (ACT) model for adults which has many features in common with adult systems of care. HCFA indicated that ACT services could be reimbursable through Medicaid.

What is Medicaid or Medi-Cal?
Medicaid is a health insurance program for low-income individuals established and funded through a state and federal partnership. States design their program within federal requirements through state plans or waiver requests. HCFA approves and monitors compliance with the state plans and, if applicable, waivers. Federal law describes the services that may be considered "medical assistance" and included in a state plan. Medical assistance includes inpatient hospital services and physician services, but also provides options for services such as targeted case management and rehabilitative services. California's Medicaid program is called Medi-Cal. The State Department of Health Services (DHS) is the single state agency responsible for the Medi-Cal program. The Medi-Cal state plan includes rehabilitative mental health services and targeted case management services for beneficiaries who have mental disorders. DHS delegates

responsibility for the administration of most Medi-Cal specialty mental health services, including rehabilitative mental health services (called the "Rehab Option") and targeted case management, to the State Department of Mental Health (DMH). Beginning in November 1997, these services have been provided by Mental Health Plans, i.e., county mental health departments under contract with DMH, through an approved federal freedom of choice waiver. The Medi-Cal program, both under the state plan and the current federal waiver, allows more flexibility in the delivery of services than the Medicare program (described below), particularly with regards to the responsibilities of licensed mental health professionals for supervision of services by other professionals or by non-licensed individuals and the sites where services can be provided.

In fiscal year 1996/97, the federal Medi-Cal reimbursement for California's public mental health outpatient services was $228 million.

What is the difference between the Clinic Option and the "Rehab Option" under Medi-Cal?

From 1971 through 1993, California's Medi-Cal reimbursement for public mental health services was based on the clinic option, one of the Medicaid services that states may include in their Medicaid state plans. California's clinic option required that services had to be directed by a physician, provided primarily in a clinic, and focused primarily on the treatment of the mental disorder. In 1989, California added targeted case management for individuals with mental disorders to its state plan. This allowed federal reimbursement for the critical case coordination services provided to individuals with mental disorders by county mental health programs. In July 1993, California proposed and received federal approval for a change in the Medicaid state plan from the clinic option to the "Rehab Option." Services under the "Rehab Option" are directed by licensed mental health practitioners, may be provided almost anywhere in the community, and may be focused both on the treatment of the mental disorder and the associated functional limitations that may jeopardize community living.

What is Medicare?

Medicare is a federally funded national health insurance system for people who are elderly or disabled. Like many private insurance programs, Medicare has established coinsurance and deductible amounts that must be paid by the covered individuals directly, through private supplemental insurance, or, in the case of individual also covered by Medi-Cal, by the Medi-Cal program. The state has no direct role in the Medicare program. In the fee-for-service Medicare program, there is a direct relationship between the provider and a Medicare fiscal intermediary. Medicare also includes an option for individuals to enroll in Medicare managed care plans. Individuals on Medicare, particularly disabled individuals, may qualify for services in California's public mental health system.

In fiscal year 1996/97, the federal Medicare reimbursement for California's public mental health outpatient services was $14 million.

Are public mental health services eligible for Medicare reimbursement?
County mental health programs may receive Medicare reimbursement when they meet the applicable federal qualifications as outpatient hospital clinics, community mental health centers, or though billings from individual practitioners. DMH is only aware of one county that has tried to qualify under the stringent requirements for outpatient hospital clinics. Although initially many counties chose to be bill Medicare as community mental health centers, most have discontinued that practice because of significant paperwork requirements and intense medical review by the Medicare fiscal intermediaries. Most outpatient public mental health services provided to clients on Medicare in California are currently billed only through qualified independent practitioners. When billing as an independent practitioner, that individual must provide the service or be directly supervising the provision of the service by another qualified individual. Counties must work directly with the Medicare fiscal intermediary or the federal Medicare program to ensure that Medicare standards are met.